

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012141</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/07/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUNRISE ON OLD MERIDIAN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>12130 OLD MERIDIAN ST</b> <b>CARMEL, IN 46032</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00142991.</p> <p>Complaint IN00142991 Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: February 6 &amp; 7, 2014</p> <p>Facility number: 012141 Provider number: NA AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: Residential: 88 Total: 88</p> <p>Census Payor type: Other: 88 Total: 88</p> <p>Sample: 5 Supplemental sample: 27</p> <p>Sunrise on Old Meridian was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00142991.</p> <p>Quality Review 02/07/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE